DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

45 LA 5/23/14

PRINTED: 04/21/2014
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445172	A. BUILDING _____ B. WING _____	04/08/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-SMITH COUNTY	112 HEALTH CARE DR CARTHAGE, TN 37030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 248 SS=E	483.15(f)(1) ACTIVITIES MEET INTERESTS/NEEDS OF EACH RES The facility must provide for an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, policy review, and interview, the facility failed to provide an adequate activities program to enrich the lives of the residents and failed to provide activities for four residents (#67,#6, #96, #59) of thirty-three residents reviewed. The findings included: Resident #67 was admitted to the facility on November 22, 2011, and readmitted on September 16, 2012, with diagnoses including Quadraplegia secondary to History of Head Trauma, Seizure Disorder and Obesity. Review of the Minimum Data Set (MDS) annual dated January 27, 2014, revealed the resident was severly cognitively impaired, never/rarely understood, and was total dependent for all activities of daily living. Review of the care plan dated February 4, 2014, revealed the care plan for activities was "...visit...1:1...needs music at bedside as tolerated...provide music visits to room as scheduled..." Observation during the survey conducted from	F 248	*This Plan of Correction is the center's credible allegation of compliance..* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F 248 1) It is the practice of this facility to provide an ongoing program of activities designed to meet in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. Resident # 67 music therapy program was initiated on 5/1/14. Resident #6 encouraged to participate in more group activities 4/10/14 and one on one visits initiated on 5/1/14. Resident #96 encouraged to participate in more group activities and one on one visits initiated on 5/1/14. Resident #59 one on one visits initiated on 5/1/14. 2) The Activity Director will complete individual assessments on residents with a BIMs score of 7 or less to identify residents' preferences and/or their ability to participate in different types of activities based on their cognitive impairment and develops an activities program to meet these preferences, as able. 3) The Activity Director will assess each resident at the time of admission and at least quarterly to ascertain activity preferences and/or ability to participate in different types of activities. The Activity Director will use this information to develop a comprehensive Activity program to accommodate the	May 20, 2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Administrator 05/01/14

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 248	Continued From page 1 April 6, through April 8, 2014, revealed no activites for the resident. Interview with the Activities Director on April 7, 2014. at 3:15 p.m., at the nurses' station, revealed no documentation of activities for the resident. Continued interview with the Activites Director revealed tried to provided 1:1 activites for the resident. Continued interview with the Activities Director confirmed it had been at least 9 months since the resident was provided activites. Review of the Activities calendars for November 2013 through April 2014 revealed only two activities per day, one in the morning, and one in the afternoon, were planned. Continued review of the Activities calendars revealed no activities scheduled after 2:00 p.m. Resident #6 was admitted to the facility on July 18, 2007, with diagnoses including Cerebrovascular Accident, Seizures, Hypertension, Congestive Heart Failure, Gastroesophageal Reflux Disease, and Arteriosclerotic Cardiovascular Disease. Medical record review of the annual Minimum Data Set (MDS) dated March 3, 2014, revealed the resident was total dependence for transfers, bathing, dressing, grooming, and toileting; and was moderately impaired cognitively. Medical record review of the resident's Pleasant and Meaningful Activities dated January 10, 2011, revealed the resident liked going to church; listening to gospel music; reading the Bible and Bible stories; and reminiscing. Medical record review of the Individual Participation Records for January through March	F 248	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* residents' ability to participate in activities related to their cognitive abilities and preferences. The Activities Director will inservice the activities assistant and volunteers that assist with activities on appropriate activities for cognitively impaired residents. 4) The Activity Director will audit the residents participation record of residents who are cognitively impaired for participation in activities at least monthly for three months, then at least quarterly. The Activities Director, or designee, reports the results of the audits at the monthly PI committee meeting for review and new recommendations to be determined at that time. The PI committee members consist of the Medical Director, Executive Director, Director of Nursing, Activities Director, Social Services Director, Staff Development Coordinator, Dietary Director, and Assistant Director of Nursing. The Administrator is responsible for overall compliance.	

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F 248	Continued From page 2 2014, revealed the sections on TV/radio/music, talking/conversing/telephone, and visit with family or friends was marked as "I" or individual participation every day of the month. Medical record review of the care plan revealed a problem identified on July 31, 2007, of activity deficit as evidenced by "...requires invitation and escort to out-of-room group activities of choice, confusion, does not attend most group activities due to anxiety..." with a goal established on March 11, 2014, which stated "...will not show signs of agitation during 1:1 visits 2x (times) week during the next quarter..." Continued review of the care plan revealed interventions included "...encourage to attend out-of-room group activities; up most in am, naps in pm; pray with resident when...asks, read the Bible to...as desired; assist with mail as needed; TV in room..." Observation of the resident on April 6, 2014, revealed the resident was at the nurses' station in a reclining wheelchair, sound asleep from 1:00 p.m. to 3:00 p.m. Continued resident observation on April 7, 2014, revealed the resident in the hall near the nurses' station, in a reclining wheelchair from 8:15 a.m. through lunch until 3:00 p.m. asleep. Further observation on April 8, 2014, revealed the resident in a reclining wheelchair at the nurses' station from 7:45 a.m. to 3:30 p.m. Observation of the dining room revealed the Activities Director was doing nail care and an assistant was engaged in ball tossing with residents. Continued observation revealed resident #6 was not included in either activity even though the resident was sitting in the hall adjacent to the dining room.	F 248		

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F 248	Continued From page 3 Resident #96 was admitted to the facility on December 6, 2011, with diagnoses including Urinary Tract Infection, Hypertension, Hyperlipidemia, Hematuria, and Anorexia. Medical record review of the quarterly MDS dated March 24, 2014, revealed the resident was totally dependent for grooming and toileting; required extensive assistance with dressing, bathing, and transfers; and scored 3/15 on the Brief Inventory of Mental Status, with a score of 15 being alert and oriented. Medical record review of the Pleasant and Meaningful Activities dated December 30, 2011, revealed the resident liked pet therapy; church, county news; outdoor time; reading; and reminiscing. Medical record review of the Individual Participation Records dated January through March 2014, revealed the sections on TV/radio/movies, talking/conversing/telephone, and visit with family or friends were marked with an "I", indicating an individual activity. Medical record review of the care plan initiated on October 23, 2013, revealed a problem of Activity Deficit as related to confused, hard-of-hearing, does not attend group activities. Continued review of the care plan revealed approaches included provide invitation and escort to out-of-room group activities of interest; visit 1:1 to establish trust and assess for any independent activity needs; assist with mail as needed; and honor religious beliefs. Observation of the resident on April 6, 2013, revealed the resident was in bed and family was	F 248		

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F 248	Continued From page 4 visiting. Observation of the resident on April 7, 2014, revealed the resident was up in rock n go chair at 8:30 a,m, and sitting in the hall by the nurses' station. Continued observation of the resident on April 8, 2014, at 10:00 a.m., 11:00 a.m., 1:00 p.m., 2:00 p.m., and 3:15 p.m., revealed the resident was sitting in the hall near the nurses' station. Observation of the dining room revealed the Activities Director was doing nail care and an assistant was engaged in ball tossing with residents. Continued observation revealed resident #96 was not included in either activity even though the resident was sitting in the hall adjacent to the dining room. Resident #59 was admitted to the facility on August 10, 2013, and readmitted on September 4, 2013, with diagnoses including Dementia, Hypothyroidism, Hypertension, and Parkinson's Disease Medical record review of the quarterly MDS dated March 4, 2014, revealed the resident was totally dependent for dressing and grooming; required extensive assistance with transfers and bathing; and was moderately impaired cognitively. Medical record review of the Pleasant and Meaningful Activities revealed the resident was very social; liked games and puzzles; was active in church; liked old country and gospel music; and liked movies and football. Medical record review of the Individual Participation Records for January through March 2014, revealed the sections on TV/radio/movies; talking/conversing/telephone; and visit with family	F 248		

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F 248	Continued From page 5 or friends were marked with an "I", meaning individual activity, every day of the month. Medical record review of the care plan revealed a problem with activities deficit as related to confused, not able to make needs known, was identified on February 5, 2013. Continued review of the care plan revealed approaches included provide invitations and escort to out-of-room group activities of interest; assist with mail as needed; visit 1:1 to establish trust and assess for independent activity needs; try clothes folding activity when anxious to redirect. Observation of the resident on April 6, 2014, at 1:45 p.m., revealed the resident sitting in the hall near the nurses' station. Continued observation of the resident on April 7, 2014, at 8:15 a.m., 10:00 a.m., 11:15 a.m., 1:35 p.m., 2:30 p.m., and 3:45 p.m., revealed the resident sitting in a wheelchair near the nurses' station. Further observation on April 8, 2014, at 9:20 a.m. to 11:00 a.m., and 2:00 p.m. to 3:30 p.m., revealed the resident seated in a wheelchair in the hall near the nurses' station. Review of the facility policy entitled "Activity Programs" revealed an activity program is designed to appeal to resident's interests & to enhance resident's highest practicable level of physical, mental, & psychosocial well-being. Any resident who is confined or chooses to remain in room is provided with in-room recreation programs in keeping with life-long interests. Interview with the Activities Director on April 8, 2014, at 9:40 a.m., in the dining room, revealed the residents like to sit in the hall and watch things since they are hard of hearing. Continued interview with the Activities Director confirmed	F 248		

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F 248	Continued From page 6 residents #6, #96, and #59 were not part of a structured activities program.	F 248	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.*	
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to revise the care plan for one resident (#115) for urinary incontinence; failed to revise the care plan for the significant weight loss for one resident (#116), of thirty-three residents reviewed. The findings included:	F 280	F280 1) Resident # 115 and #116 no longer reside in the facility. 2) The Clinical Case Manager, or her designee, will review the comprehensive care plans of residents who are identified as having incontinence and significant weight loss to ensure that specific needs related to the coordination of care of those areas are addressed. 3) The Clinical Case Manager, or her designee, will in-service the Interdisciplinary Care Planning Team on development of comprehensive care plans with an emphasis on the specific needs residents with incontinence and resident who have been identified as having a significant weight loss. The Clinical Case Manager and the IDT members will review the comprehensive care plan of each resident that triggered for incontinence and a significant weight loss on at least a quarterly basis to assure specific needs related to these areas are addressed. 4) The Director of Nursing, or her designee, will monitor through resident record review, at least monthly for three months, then at least quarterly, to assure the special needs of residents who are incontinent and have had a significant weight loss are addressed. The Director of Nursing, or his designee, reports the results of the audits at the monthly PI	May 20, 2014

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F 280	Continued From page 7 Resident #115 was admitted to the facility on December 26, 2013, with diagnoses including Multiple Myeloma, Acute Blood Loss, Renal Failure, Hypertension, Dementia, and Diabetes. Review of the admission Minimum Data Set dated admission January 2, 2014, revealed the resident was occassionally incontinent of voiding. Review of the significant change Minimum Data Set (MDS) dated January 21, 2014, revealed the resident had short/long term memory problems, cognitive skill for decision making were modified independence, total dependent for toilet use and personal hygiene, always incontinent of voiding. Review of the care plan dated January 2, 2014, revealed no update for the significant change of always incontinent of voiding. Interview with MDS Coordinator on April 8, 2014, at 1:00 p.m., in the MDS office, confirmed the resident had a significant change on January 21, 2014. Continued interview confirmed the resident had a decline in health and had become incontinent of voiding. Continued interview with the MDS Coordinator confirmed the care plan dated January 2, 2014, had not been updated to reflect the resident's urinary incontinence. Resident #116 was admitted to the facility on October 18, 2013, and readmitted to the facility on November 15, 2013, with diagnoses including Recurrent Syncope Episodes, Diabetes Mellitus Type 2, Stage 3 Chronic Kidney Disease, Chronic Venous Ulcers, Bipolar Disorder, Hypertension, Clostridium Difficile, and Edema. Further review revealed the resident was discharged from the facility to the home with home health services on	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* committee meeting for review and new recommendations to be determined at that time. The PI committee members consist of the Medical Director, Executive Director, Director of Nursing, Activities Director, Social Services Director, Staff Development Coordinator, Dietary Director, and Assistant Director of Nursing. The Administrator is responsible for overall compliance.	

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F 280	Continued From page 8 January 28, 2014. Medical record review of the Individual Resident Weight History revealed the weight at admission (11/15/2013) was 275 pounds (lbs.). Further review revealed the weight at 15 days after admission was 268 lbs. (which is 7 lbs. less than at admission or a 2.5% loss). Further review revealed the weight at 30 days after admission was 242 lbs. (which is 33 lbs. less than at admission or a 12.0% loss). Further review revealed the weight at 60 days after admission was 234 lbs. (which is 41 lbs. less than at admission or a 14.9% loss). Medical record review of the Minimum Data Set dated December 13, 2013, and January 10, 2014, revealed the resident experienced significant weight loss and was not under a physician ordered weight loss regime. Medical record review of the physician phone order dated December 4, 2013, revealed "...protein shake (propass with glucema- a protein supplement with a diabetic supplement) with meals; Peanut butter with crackers at AM (morning) + (and) PM (evening) snack..." Medical record review of the Medical Nutritional Therapy Assessment dated November 21, 2013, revealed the Body Mass Index (measure amoun tof fat in the body) was elevated, the Ideal Body Weight Range (IBWR) was 154 lbs. +/- (plus/minus) 10 % (percent), and the resident was at 174% of the IBWR with the weight of 268.5 lbs. Medical record review of the care plan dated December 3, 2013, revealed the concern area of	F 280		

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F 280	Continued From page 9 "Overweight/Obesity, as related to an increased Body Mass Index/Ideal Body Weight Range..." Further review revealed the goal was "will maintain present weight +/- (plus/minus) 5 lbs." Further review revealed the care plan was not updated to reflect the weight loss. Interview on April 7, 2014, at 2:50 p.m. and 4:32 p.m., with the Registered Dietitian and the Dietary Supervisor, in the conference room, confirmed the care plan was not revised to address the weight loss.	F 280	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* F281 1) It is the practice of this facility to follow physician's orders. Resident #77 sustained no adverse reactions from being administered the medication. 2) The resident's physician was notified immediately on 4/7/14. The medication was discontinued and removed from the medication administration record and from the medication cart. Resident #77 blood glucose results were monitored per MD order and no adverse reactions were noted. 2) The Director of Nursing and/or the nursing administration conducted an audit of the medication administration records of all residents to ensure the accuracy of residents' medications. 3) The Staff Development Coordinator conducted an in-service with the licensed staff on meeting professional standards with an emphasis on how to process physicians orders. The Staff Development Coordinator will include information regarding meeting professional standards of quality, to include how to process physician's orders, in the orientation of new licensed personnel. Licensed nurses on the night shift will review all new orders in the 24 hour chart check process to ensure accuracy in the processing of orders. Corrections will be made at the time an error is noted and the	May 20, 2014
F 281 SS=D	483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS The services provided or arranged by the facility must meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to follow the physician's orders for one resident (#77) of thirty-three residents reviewed. The findings included: Resident #77 was admitted to the facility on November 1, 2013, with diagnoses including Acute Back Pain, Diabetes, Hypertension, Chronic Kidney Disease, and Atrial Fibrillation. Observation during a medication pass on April 7, 2014, at 7:40 a.m., on the three hundred hall, revealed Registered Nurse #1 (RN), administered Glimepiride (antidiabetic drug used with type 2 Diabetes that can't be controlled by diet alone) 2	F 281		

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F 281	Continued From page 10 mg (milligram). Review of the physician's orders dated March 25, 2014, revealed discontinue Glimepiride. Interview with RN #1 on April 7, 2014, at 8:25 a.m., on the three hundred hallway, confirmed the order was to discontinue the Glimepiride. Continued interview confirmed RN #1 had administered the medication.	F 281	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* physician notified.	
F 318 SS=D	483.25(e)(2) INCREASE/PREVENT DECREASE IN RANGE OF MOTION Based on the comprehensive assessment of a resident, the facility must ensure that a resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, the facility failed to ensure the appropriate palm guards were in place for one resident (#67), of three residents reviewed for range of motion. The findings included: Resident #67 was admitted to the facility on November 22, 2011, and readmitted on September 16, 2012, with diagnoses including Quadraplegia secondary to History of Head Trauma, Seizure Disorder and Obesity.	F 318	4) The Director of Nursing and the Nursing administration team will review new Physician Orders Monday-Friday in Clinical rounds and validate the accuracy of 25% of those orders weekly times 4 weeks, then audit the accuracy of 10% of physician orders monthly times 3 months and the quarterly until the PI committee determines if the audits need to continue. The Director of Nursing, or 0.designee, report the results of the audits at the monthly PI committee meeting for review and new recommendations to be determined at that time. The PI committee members consist of the Medical Director, Executive Director, Director of Nursing, Activities Director, Social Services Director, Staff Development Coordinator, Dietary Director, and Assistant Director of Nursing. The Administrator is responsible for overall compliance.	

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	445172	A. BUILDING _____ B. WING _____	04/08/2014

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F 318	Continued From page 11 Review of the annual Minimum Data Set (MDS) dated January 27, 2014, revealed the resident was severly cognitively impaired, never/rarely understood, was totally dependent for all activities of daily living. Review of the physician's orders dated March 26, 2014, revealed d/c (discontinue) bilateral palm guards; bilateral palm guards with finger seperations. Review of the care plan dated February 4, 2014, revealed bilateral palm guards with finger seperators to wear at all times except for bathing. Observation on April 6, 2014, at 1:45 p.m., in the resident's room, revealed the resident had bilateral palm guards with no finger seperators. Observation on April 7, 2014, at 7:45 a.m., revealed the resident had bilateral palm guards with no finger seperators. Observation and interview on April 7, 2014, at 3:05 pm., in the resident's room, with the MDS Coordinator, confirmed the resident had the bilateral palm guards with no finger seperators. Continue interview with the MDS Coordinator confirmed the bilateral palm guards with the finger seperators were not in place.	F 318	F318 1)The facility will continue to strive to ensure that residents receive appropriate treatment and services to increase range of motion. Resident #67 order was reviewed and the palm guard with finger separators was applied on 4/7/2014. Resident #67 experience no signs of a decline in range of motion and the appropriate palm guard has been in place per physician's order. 2) Clinical records have been reviewed of all residents with assistive devices related to the prevention and/or decline in range of motion. An audit of all residents' care plans that were identified in the review of assistive devices related to prevention and/or decline in range of motion were updated as needed with the assistive device and interventions.	May 20, 2014
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate	F 329		

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F 329	Continued From page 12 indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview the facility failed to ensure one resident (#77) was free from unnecessary drugs of six resident reviewed. The findings included: Resident #77 was admitted to the facility on November 1, 2013, with diagnoses including Acute Back Pain, Diabetes, Hypertension, Chronic Kidney Disease, and Atrial Fibrillation. Observation during a medication pass on April 7, 2014, at 7:40 a.m., on the three hundred hall, revealed Registered Nurse #1 (RN), administered Glimepiride (antidiabetic drug used with type 2	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 3) The nurses and certified nursing assistants will be re-inserviced on the application of assistive devices for the prevention and/or decline in range of motion by the Staff Development Coordinator. The SDC or designee will inservice appropriate personnel of the proper application of splints during new hire orientation. 4) The Restorative Nurse or designee will monitor the application of 25% of the assistive devices to ensure the appropriate device is in place, care plan and documented times 4 weeks, then 10% monthly times 3 months, and then quarterly until the PI committee determines that compliance has been met. Any employee identified as not applying splints per physician order will be in-serviced and/or counseled. The results of the audits will be reviewed at the montly PI meeting. The data will be reviewed and analyzed with a subsequent action plan developed as indicated. The PI committee members consist of the Medical Director, Executive Director, Director of Nursing, Activities Director, Social Services Director, Staff Development Coordinator, Dietary Director, and Assistant Director of Nursing. The administrator is responsible for overall compliance. F 329 1) The RN #1 contracted the Resident #77	May 20, 2014

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F 329	Continued From page 13 Diabetes that can't be controlled by diet alone) 2 mg (milligram). Reviews of the physician's orders dated March 25, 2014, revealed discontinue Glimepiride. Interview with RN #1 on April 7, 2014, at 8:25 a.m., on the three hundred hallway, confirmed the order was to discontinue the Glimepiride. Continued interview confirmed RN #1 had administered the medication. Interview with the Director of Nursing (DON) on April 8, 2014, at 9:20 a.m., in the DON's office, confirmed the resident received 7 doses of Glimepiride for the month of April, 2014, after the drug was to be stopped on March 25, 2014.	F 329	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* physician immediately to notify him of the medication that was given in error. A medication error report was completed on 4/7/14. The medication was discontinued off the medication administration record and removed from the medication cart. Resident #77 blood glucose levels were monitored per physician's order with no adverse reactions noted. 2) The Director of Nursing and/or the nursing administration conducted an audit of the medication administration records of all residents to ensure the accuracy of residents' medications. 3) The Staff Development Coordinator conducted an in-service with the licensed staff on meeting professional standards with an emphasis on how to process physicians orders. The Staff Development Coordinator will include information regarding meeting professional standards of quality, to include how to process physician's orders, in the orientation of new licensed personnel. Licensed nurses on the night shift will review all new orders in the 24 hour chart check process to ensure accuracy in the processing of orders. Corrections will be made at the time an error is noted and the physician notified. 4) The Director of Nursing and the Nursing administration team will review new	
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections.	F 441		

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F 441	Continued From page 14 (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, facility policy review, and interview, the facility failed to follow to follow proper infection control practices, and facility policy by leaving an ice scoop in one of four ice chests. The findings included: Observation on April 6, 2014, at 2:55 p.m., on the 600 hall, revealed an ice scoop in an ice chest. Review of the facility policy Passing Ice Water to Residents revealed, "...Avoid leaving ice scoop in the ice chest..."	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* Physician Orders Monday-Friday in Clinical rounds and validate the accuracy of 25% of those orders weekly times 4 weeks, then audit the accuracy of 10% of physician orders monthly times 3 months and the quarterly until the PI committee determines if the audits need to continue. The Director of Nursing, or his designee, report the results of the audits at the monthly PI committee meeting for review and new recommendations to be determined at that time. The PI committee members consist of the Medical Director, Executive Director, Director of Nursing, Activities Director, Social Services Director, Staff Development Coordinator, Dietary Director, and Assistant Director of Nursing. The Administrator is responsible for overall compliance. F441 1) It is the practice of this facility to maintain an infection control program designed to provide a safe, sanitary and comfortable environment to aid in the prevention and transmission of infection. The ice scoop was removed from the identified ice chest. The ice was discarded from the ice chest and the ice chest was sanitized on 4/06/14. The C.N.A. was provided a 1:1 coaching session which included the proper procedure to be used when passing ice water to residents on 4/07/14.	May 20, 2014

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F 441	Continued From page 15 Interview with the Maintenance Director on April 6, 2014, at 2:55 p.m., on the 600 Hall confirmed the ice scoop was left in the ice chest.	F 441	*This Plan of Correction is the center's credible allegation of compliance.* *Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.* 2) The Director of Nursing checked the 3 remaining ice chests to ensure the ice scoop was stored properly on 4/06/14. 3) The Staff Development Coordinator will in-service the current nursing personnel on Infection control procedures to be followed when passing ice water to residents. The Director of Nursing, or her designee, will re-in-service and/or counsel any employee identified as not performing proper procedure while passing ice water as delineated by the facility policy and procedure. 4) The Director of Nursing, or her designee, will monitor through direct observation of nursing staff performing ice water pass 3 times a week for 4 weeks and then weekly for 3 months, to assure nursing personnel are performing proper procedure during passing of ice water. The results of these observations will be reported to the monthly PI committee meeting meeting for review and new recommendations to be determined at that time. The PI committee members consist of the Medical Director, Executive Director, Director of Nursing, Activities Director, Social Services Director, Staff Development Coordinator, Dietary Director, and Assistant Director of Nursing. The Administrator is responsible for overall compliance.	